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UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

FREDA SUSSMAN, Plaintiff, v. ARMELIA SANI, M.D., SHILEY EYE CENTER, UCSD MEDICAL CENTER, REGENTS OF THE UNIVERSITY OF CALIFORNIA, HEALTH NET, INC., HEALTH NET SENIORITY PLUS, LINDA BEACH, HAIDEE GUTIERREZ, and DOES 1 through 40, inclusive, Defendants.	CASE NO. 08 CV 0392 H BLM Honorable Marilyn L. Huff Action Removed: March 3, 2008 **REQUEST FOR JUDICIAL NOTICE IN SUPPORT OF HEALTH NET OF CALIFORNIA, INC.'S MOTION TO DISMISS ACTION, PURSUANT TO FEDERAL RULES OF CIVIL PROCEDURE 12(b)(1) AND 12(b)(6); DECLARATION OF MARCI ARMIN IN SUPPORT THEREOF** [Filed concurrently with Notice of Motion and Motion to Dismiss] DATE: April 7, 2008 TIME: 10:30 a.m. CTRM: 13

TO THE HONORABLE COURT AND TO ALL PARTIES AND THEIR COUNSEL OF RECORD:

Pursuant to Rule 201, Federal Rules of Evidence, defendant Health Net of California, Inc. ("Health Net") hereby requests that the Court take judicial notice of the Health Net Seniority Plus Medicare Supplement contract in effect between

LEWIS BRISBOIS BISGAARD & SMITH LLP
221 NORTH FIGUEROA STREET, SUITE 1200
LOS ANGELES, CALIFORNIA 90012-2601
TELEPHONE (213) 250-1800

Health Net and plaintiff Freda Sussman between January 1, 2007 and December 31, 2007.

A true and correct copy of the contract is attached hereto as Exhibit "A" to the declaration of Marci Armin.

DATED: March 10, 2008

LEWIS BRISBOIS BISGAARD & SMITH LLP

By s/Kristin P. Kyle de Bautista
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DECLARATION OF MARCI ARMIN

I, Marci Armin, declare as follows:

1. Since 1995 I have been the Manager of the Legal Affairs Department at Health Net of California, Inc. ("Health Net"). My responsibilities include managing the Legal Affairs Department, resolving regulatory issues and consumer inquiries, and serving as the custodian of records for Health Net. Based upon my review of information maintained by Health Net in the normal course of its business, I have personal knowledge of the information set forth in this Declaration and, if called upon to testify, could and would competently testify to the truth thereof.

2. Attached hereto as Exhibit A is a true and correct copy of the contract between Health Net and Freda Sussman in effect Between January 1, 2007 and December 31, 2007.

I declare under penalty of perjury under the laws of the State of California and of the United States that the foregoing is true and correct.

Executed on March 7, 2008 at Woodland Hills, California.

Marci Armin

MARCI ARMIN

EXHIBIT "A"

Health Net
Medicare Programs

A COMPLETE

explanation of your plan

Effective Date
From: 01/01/2007
To: 12/31/2007

Evidence of Coverage &
Disclosure of Information
Health Net Seniority Plus Ruby

San Diego County Plan 2

PLAN 040 148745

EVIDENCE OF COVERAGE:

Your Medicare Health Benefits and Services
as a Member of Health Net Seniority Plus Ruby

January 1 – December 31, 2007

This booklet gives the details about your Medicare health coverage and explains how to get the care you need. This booklet is an important legal document. Please keep it in a safe place.

Health Net Member Services:

For help or information, please call Member Services seven days a week, from 8 am to 8 pm. A customer service representative will be available to answer your call directly during the annual enrollment period and 60 days after from 8 am until 8 pm, seven days a week. However, after March 2, 2007, your call will be handled by our automated phone system, Saturdays, Sundays and holidays. When leaving a message, please include your name, number and the time that you called, and a representative will return your call shortly. Calls to these numbers are toll free:

1-800-275-4737

TTY: 1-800-929-9955

Welcome to Health Net Seniority Plus

Welcome to Health Net Seniority Plus Ruby (Seniority Plus)!

We are pleased that you've chosen Seniority Plus.

Seniority Plus is a **H**ealth **M**aintenance **O**rganization "HMO" for people with Medicare.

Now that you are enrolled in Seniority Plus, you are getting your care through Health Net of California, Inc. (Health Net). Seniority Plus, an HMO, is offered by Health Net. **(Seniority Plus is not a "Medigap" or supplemental Medicare insurance policy.)**

This booklet explains how to get your Medicare services through Seniority Plus.

This booklet, together with your enrollment form and any amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a Member of Seniority Plus. It also explains our responsibilities to you. The information in this booklet is in effect for the time period from January 1, 2007, through December 31, 2007.

You are still covered by Original Medicare, but you are getting your Medicare services as a Member of Seniority Plus. This booklet gives you the details, including:

- What is covered by Seniority Plus and what is not covered.
- How to get the care you need, including some rules you must follow.
- What you will have to pay for your health plan.
- What to do if you are unhappy about something related to getting your covered services.
- How to leave Seniority Plus, and other Medicare options that are available.

If you need to receive this booklet in a different format (such as in Spanish, large print), please call us so we can send you a copy. Section 1 of this booklet tells how to contact us.

Please tell us how we're doing.

We want to hear from you about how well we are doing as your health plan. You can call or write to us at any time (Section 1 of this booklet tells how to contact us). Your comments are always welcome, whether they are positive or negative. From time to time, we do surveys that ask our members to tell about their experiences with Seniority Plus. If you are contacted, we hope you will participate in a member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

Table of Contents

Section 1 Telephone numbers and other information for reference

How to contact Health Net Member Services

If you have any questions or concerns, please call or write to Health Net Member Services. We will be happy to help you. Our business hours are 8:00 a.m. to 8:00 p.m., 7 days a week.

CALL	**1-800-275-4737**. This number is also on the cover of this booklet for easy reference. Calls to this number are free.
TTY	**1-800-929-9955**. This number requires special telephone equipment. It is on the cover of this booklet for easy reference. Calls to this number are free.
WRITE	Health Net Seniority Plus, Post Office Box 10198, Van Nuys, California, 91410-0198.

How to contact the Medicare program and the 1-800-MEDICARE (TTY 1-877-486-2048) helpline

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). CMS is the federal agency in charge of the Medicare program. CMS stands for Centers for Medicare & Medicaid Services. CMS contracts with and regulates Medicare Health Plans (including Health Net).

Here are ways to get help and information about Medicare from CMS:

- Call **1-800-MEDICARE** (**1-800-633-4227**) toll free to ask questions or get free information booklets from Medicare. You can call this national Medicare helpline 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048.**
- Use a computer to look at www.medicare.gov, the official **government website for Medicare information.** This website gives you a lot of up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Prescription Drug Plans in your area. You can also search the "Helpful Contacts" section for the Medicare contacts in your state. If you do not have a computer, your local library or senior center may be able to help you visit this website using their computer.

Health Insurance Counseling and Advocacy Program (HICAP) – an organization in your state that provides free Medicare help and information

HICAP is a state organization paid by the federal government to give free health insurance information and help to people with Medicare. HICAP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. HICAP has information about Medicare Advantage Plans and about Medigap (Medicare Supplement Insurance) policies. This includes information about whether to drop your Medigap policy while enrolled in the Medicare Advantage plan. This also includes special Medigap rights for people who have tried a Medicare Advantage Plan (like Seniority Plus) for the first time. (Medicare Advantage is the new name for Medicare + Choice). Section 13 has more information about your Medigap guaranteed issue rights.

You can contact HICAP at:

Elder Law and Advocacy
3675 Ruffin Road, Suite 315
San Diego, CA 92123
1-858-565-8772 or **1-800-434-0222**
TTY/TDD users should call the California Relay Service at **711** or **1-800-735-2929**. Calls to these numbers are free.

You can also find the website for HICAP at www.medicare.gov on the web.

Lumetra (Quality Improvement Organization – QIO) – a group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare

"QIO" stands for Quality Improvement Organization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. In California, the QIO is called Lumetra. The doctors and other health experts in Lumetra review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation stay is ending too soon. See Section 10 for more information about complaints.

You can contact Lumetra at:

Lumetra Headquarters
One Sansome Street, Suite 600
San Francisco, CA 94104
1-415-677-2000 or **1-800-841-1602** (TDD/TTY at **1-800-881-5980**)

Other organizations (including Medicaid, Social Security Administration)

Medicaid agency – a state government agency that handles health care programs for people with low incomes

In the State of California, Medicaid is also known as Medi-Cal. Medicaid is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medicaid. Most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid also has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact:

Department of Health and Human Services Agency
(Call for the nearest district office)
1-858-514-6885
TTY/TDD **1-800-325-0778**

Social Security Administration

The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits, disability, family benefits, survivors' benefits, and benefits for the aged, blind, and disabled. You can call the Social Security Administration toll free at **1-800-772-1213**. TTY users should call **1-800-325-0778**. You can also visit www.ssa.gov on the web.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you can call your local Railroad Retirement Board office or **1-800-808-0772** (calls to this number are free). TTY users should call **1-312-751-4701**. You can also visit www.rrb.gov on the web.

Employer (or "Group") Coverage

If you get your benefits from your current or former employer, or your spouse's current or former employer, call the employer's benefits administrator if you have any questions about your benefits, plan premiums, or the open enrollment season.

Section 2 Getting the care you need, including some rules you must follow

Section 6 describes our coverage rules associated with our outpatient prescription drug coverage.

What is Seniority Plus?

Now that you are enrolled in Seniority Plus, you are getting your Medicare through Health Net. Seniority Plus is offered by Health Net, and is an HMO for people with Medicare. The Medicare program pays us to manage health services for people with Medicare who are members of Seniority Plus. (Seniority Plus is **not** a Medicare supplement policy. See Section 17 for a definition of Medicare supplement policy. Medicare supplement policies are sometimes called "Medigap" insurance policies.) Health Net provides medical services through Medicare-certified health care facilities. In addition, our health care professionals are in compliance with Medicare credentialing standards.

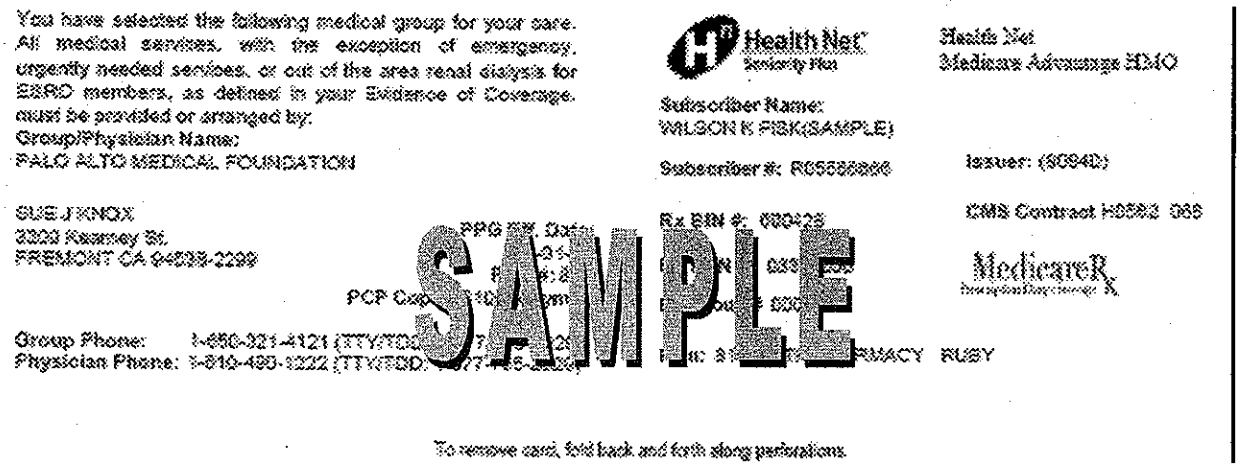
This booklet explains your benefits and services, what you have to pay, and the rules you must follow to get your care. Seniority Plus gives you all of the usual Medicare benefits and services that Medicare covers for everyone. We also give you some additional services, such as unlimited hospital day coverage.

Since Seniority Plus is a Medicare HMO, this means that you will be getting most or all of your health services from the doctors, hospitals, and other health providers that are part of Seniority Plus. These doctors, hospitals, and other providers are the ones we are paying to provide your care, so they are the ones you must use (except in special situations such as emergencies).

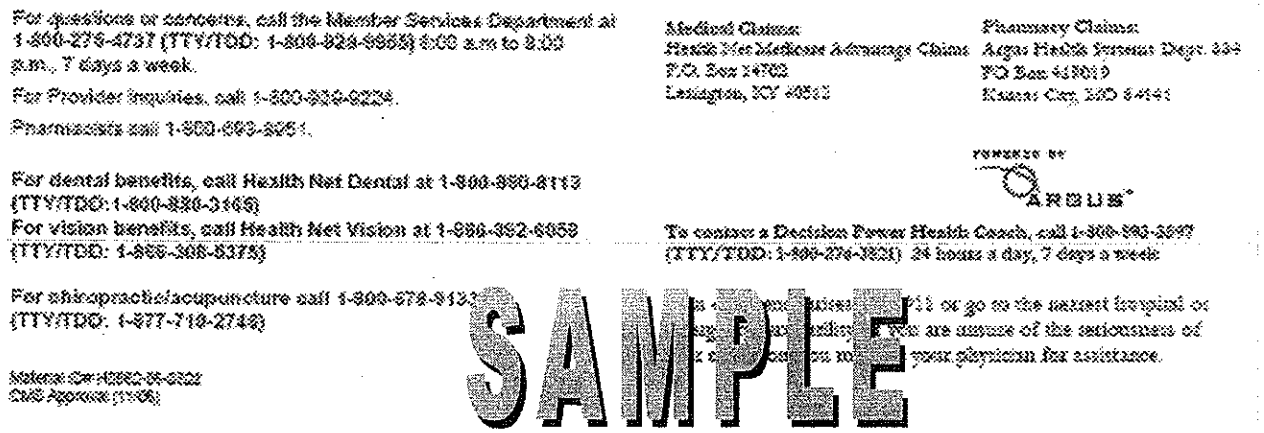
Use your plan membership card instead of your red, white, and blue Medicare card

Now that you are a Member of Seniority Plus, you have a Seniority Plus membership card. Here is a sample card to show what it looks like:

Front



Back



During the time you are a Plan Member and using plan services, **you *must* use your plan membership card instead of your red, white, and blue Medicare card to get covered services.** (See Section 4 for a definition and list of covered services.) Keep your red, white, and blue Medicare card in a safe place in case you need it later. If you get covered services using your red, white, and blue Medicare card instead of your Seniority Plus membership card while you are a Plan Member, the Medicare program will not pay for these services and you may have to pay the full cost yourself.

Please carry your Seniority Plus membership card with you at all times. You will need to show your card when you get covered services. You may also need it to get your prescriptions at the pharmacy. If your membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

Help us keep your membership record up to date

Health Net has a membership record about you as a Plan Member. Doctors, hospitals, pharmacists, and other plan providers use this membership record to know what services and drugs are covered for you. The membership record has information from your enrollment form, including your address and telephone number. It shows your specific Seniority Plus coverage, the Primary Care Physician and Medical Group you chose when you enrolled, and other information. Section 9 tells how we protect the privacy of your personal health information.

Please help us keep your membership record up to date by letting Member Services know right away if there are any changes to your name, address, or phone number, or if you go into a nursing home. Also, tell Member Services about any changes in health insurance coverage you have from other sources, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims from an automobile accident. See Section 1 for how to contact Member Services.

What is the geographic Service Area for Seniority Plus?

The counties in our Service Area are listed below:

San Diego County

Using plan providers to get services covered by Seniority Plus

You will be using plan providers to get your covered services

Now that you are a Member of Seniority Plus **you must use plan providers to get your covered services** with few exceptions.

- **What are "plan providers"?** "Providers" is the term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. We call them "plan providers" when they participate in Seniority Plus. When we say that plan providers "participate in Seniority Plus," this means that we have arranged with them to coordinate or provide covered services to members of Seniority Plus.
- **What are "covered services"?** "Covered services" is the general term we use in this booklet to mean all the medical care, health care services, supplies, and equipment that are covered by Seniority Plus. Covered services are listed in the Benefits Chart in Section 4.

As we explain below, you will have to choose one of our plan providers to be your PCP, which stands for Primary Care Physician. Your PCP will provide or arrange for most or all of your covered services. Care or services you get from non-plan providers will not be covered, with few exceptions such as emergencies. (When we say "non-plan providers," we mean providers that are **not** part of Seniority Plus.)

The Provider Directory gives you a list of plan providers

Every year as long as you are a Member of Seniority Plus, we will send you either a Provider Directory or an update to your Provider Directory, which gives you a list of plan providers. If you don't have the Provider Directory, you can get a copy from Member Services (see Section 1 for how to contact Member Services). You can ask Member Services for more information about plan providers, including their qualifications and experience. Member Services can give you the most up-to-date information about changes in plan providers and about which ones are accepting new patients. Or visit our web site at www.healthnet.com to find a Seniority Plus participating physician in your area. Access to care and information from plan providers

You have the right to get timely access to plan providers and to all services covered by the plan. ("Timely access" means that you can get appointments and services within a reasonable period of time.) You have the right to get full information from your doctors when you go for medical care. You have the right to participate fully in decisions about your health care, which includes the right to refuse care. Please see Section 9 for more information about these and other rights you have, and what you can do if you think your rights have not been respected.

Choosing Your PCP (PCP means Primary Care Physician)

What is a "PCP"?

When you become a Member of Seniority Plus, you must choose a plan provider to be your PCP. Your PCP is a health care professional who meets state requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a Plan Member. For example, in order to see a specialist, you usually need to get your PCP's approval first (this is called getting a "referral" to a specialist).

How do you choose a PCP?

When you enroll in Seniority Plus, you will select a contracting Medical Group from our network. You'll also choose a PCP from this contracting Medical Group, which you will need to indicate on your enrollment form and submit to Health Net. You can find a list of all contracting Medical Groups (and their affiliated PCP's and hospital affiliations) from the Seniority Plus Provider Directory. To confirm the availability of a provider, or to ask about a specific PCP, please contact our Member Services Department. See Section 1 for how to contact Member Services.

Once Health Net receives your enrollment form with the PCP you have chosen, we will send you a letter confirming your effective date of enrollment. A New Member Kit with your ID card reflecting your choice of PCP will also be sent.

If there is a particular Seniority Plus specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist, or uses that hospital. The name and office telephone number of your PCP is printed on your membership card.

For information on how to change your PCP, please see the "How to change your PCP" portion of this section.

Getting care from your PCP

You will usually see your PCP first for most of your routine health care needs. There are only a few types of covered services you can get on your own, without contacting your PCP first except as we explain below and in Section 4.

Your PCP will provide most of your care and help arrange or coordinate the rest of the covered services you get as a Plan Member. This includes your x-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions, and follow-up care. "Coordinating" your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, your PCP must give approval in advance (such as giving you a referral to see a specialist). In some cases, your PCP will also need to get prior authorization (prior approval). Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Section 9 tells how we will protect the privacy of your medical records and personal health information.

What if you need medical care when your PCP's office is closed?

What to do if you have a medical emergency or urgent need for care

In an emergency, you should get care immediately. You do **not** have to contact your PCP or get permission in an emergency. You can dial **911** for immediate help by phone or go directly to the nearest emergency room, hospital, or urgent care center. Section 3 tells what to do if you have a medical emergency or urgent need for care.

What to do if it is not a medical emergency

If you need to talk with your PCP or get medical care when the PCP's office is closed, and it is *not* a medical emergency, call the Physician Phone number on your membership card. (TTY/TDD users should call the California Relay Service at **711** or **1-800-735-2929**). There will always be a physician on call to help you. This physician will call you back and tell you what to do. You can also call Health Net's Decision Power Health Coaches anytime, 24 hours a day, seven days a week. Health Net's Decision Power Health Coaches' phone number is **1-800-893-5597**, (TTY **1-800-276-3821**).

See Section 3 for more information about what to do if you have an urgent need for care.

Getting care from specialists

When your PCP thinks that you need specialized treatment, he or she will give you a referral (approval in advance) to see a plan specialist. A specialist is a doctor who provides health care services for a specific disease or part of the body. Specialists include oncologists (who care for patients with cancer), cardiologists (who care for patients with heart conditions), and orthopedists (who care for patients with certain bone, joint, or muscle conditions). For some types of referrals to plan specialists, your PCP may need to get approval in advance from our Medical Management Department (this is called getting "prior authorization").

It is very important to get a referral from your PCP before you see a plan specialist (there are a few exceptions, including routine women's health care that we explain later in this section). **If you don't have a referral before you receive services from a specialist, you may have to pay for these services yourself.** If the specialist wants you to come back for more care, check first to be sure that the referral you got from your PCP covers more visits to the specialist.

If there are specific specialists you want to use, find out whether your PCP sends patients to these specialists. Each plan PCP has certain plan specialists they use for referrals. This means that **the Seniority Plus specialists you can use may depend on which PCP you select.** You can generally change your PCP at any time if you want to see a plan specialist that your current PCP cannot refer you to. Later in this section, under "How to change your PCP," we tell you how to change your PCP. If there are specific hospitals you want to use, find out whether your PCP uses these hospitals.

There are some services you can get on your own, without a referral

As explained above, you will get most of your routine or basic care from your PCP, and your PCP will coordinate the rest of the covered services you get as a Plan Member. If you get services from any doctor, hospital, or other health care provider without getting a referral in advance from your PCP, you may have to pay for these services yourself – even if you get the services from a plan provider. *But there are a few exceptions:* you can get the following services on your own, without a referral or approval in advance from your PCP. You still have to pay your cost sharing, as appropriate, co-payment for these services.

- Routine women's health care, which includes breast exams, mammograms (x-rays of the breast), Pap tests, and pelvic exams. This care is covered without a referral from your PCP *only* if you get it from a plan provider.
- Flu shots and pneumonia vaccinations (as long as you get them from a plan provider).
- Emergency services, whether you get these services from plan providers or non-plan providers (see Section 3 for more information).
- Urgently needed care that you get from non-plan providers when you are temporarily outside the plan's Service Area. Also, urgently needed care that you get from non-plan providers when you are in the Service Area but, because of unusual or extraordinary circumstances, the plan providers are temporarily unavailable or inaccessible. (See Section 3 for more information about urgently needed care. Earlier in this section, we explain the plan's Service Area.)
- Renal dialysis (kidney) services that you get when you are temporarily outside the plan's Service Area. If possible, please let us know before you leave the Service Area where you are going to be so we can help arrange for you to have maintenance dialysis while outside the Service Area.

Getting care when you travel or are away from the plan's Service Area

If you need care when you are outside the Service Area, your coverage is limited. The only services we cover when you are outside our Service Area are care for a medical emergency, urgently needed care, renal dialysis, and care that Health Net or a plan provider has approved in advance. See Section 3 for more information about care for a medical emergency and urgently needed care. If you have questions about what medical care is covered when you travel, please call Member Services at the telephone number in Section 1. See Section 6 for more information about how to fill your outpatient prescriptions when you travel or are away from the plan Service Area.

How to change your PCP

You may change your PCP for any reason and your request will be effective on the first day of the month following the date Health Net receives your request. To change your PCP, call Member Services at the number shown in Section 1. When you call, be sure to tell Member Services if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and Durable Medical Equipment). Member Services will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will check to be sure the PCP you want to switch to is accepting new patients. Member Services will change your membership record to show the name of your new PCP, and tell you when the change to your new PCP will take effect. They will also send you a new membership card that shows the name and phone number of your new PCP.

What if your doctor leaves Seniority Plus?

Sometimes a PCP, specialist, clinic, or other plan provider you are using might leave the plan. If this happens, you will have to switch to another provider who is part of Seniority Plus. If your PCP leaves Seniority Plus, we will let you know, and help you switch to another PCP so that you can keep getting covered services.

Section 3 Getting care if you have a medical emergency or an urgent need for care

What is a "medical emergency"?

A "medical emergency" is when **you reasonably believe that your health is in serious danger** – when every second counts. A medical emergency includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting much worse.

What should you do if you have a medical emergency?

If you have a medical emergency:

- Get medical help as quickly as possible. Call **911** for help or go to the nearest emergency hospital, or urgent care center.. **You do not need to get approval or a referral first from your PCP (Primary Care Physician) or other plan provider.** (Section 2 tells about your PCP and plan providers.)
- Make sure that your Medical Group knows about your emergency, because your Medical Group will need to be involved in following up on your Emergency Care. You or someone else should call to tell your PCP about your Emergency Care as soon as possible, preferably within 48 hours. This number is located on your Health Net Seniority Plus ID Card.

Your Medical Group will help manage and follow up on your Emergency Care

Health Net or your Medical Group will talk with the doctors who are giving you Emergency Care to help manage and follow up on your care. When the doctors who are giving you Emergency Care say that your condition is stable and the medical emergency is over, what happens next is called "post-stabilization care." Your follow-up care (post-stabilization care) will be covered according to Medicare guidelines. In general, your Medical Group will try to arrange for plan providers to take over your care as soon as your medical condition and the circumstances allow.

What is covered if you have a medical emergency?

- You can get covered emergency medical care whenever you need it, anywhere in the world. See Section 6 for more information on how we cover outpatient prescription drugs in an emergency situation while you are outside the Service Area.
- Ambulance services are covered in situations where other means of transportation in the United States would endanger your health. Generally, the ambulance benefit is a transportation benefit, and without a transport, there is no payable service.

What if it wasn't really a medical emergency?

Sometimes it can be hard to know if you have a real medical emergency. For example, you might go in for Emergency Care – thinking that your health is in serious danger – and the doctor may say that it was not a medical emergency after all. If this happens, you are still covered for the care you got to determine what was wrong, (as long as you thought your health was in serious danger, as explained in "What is a 'medical emergency" above). However, please note that:

- If you get any additional care after the doctor says it was *not* a medical emergency, we will pay our portion of the covered additional care **only if you get it from a plan provider.**
- If you get any additional care from a *non-plan provider* after the doctor says it was not a medical emergency, we will usually *not* cover the additional care. There is an exception: we will pay our portion of the covered additional care from a non-plan provider if you are out of our Service Area, as long as the additional care you get meets the definition of "urgently needed care" that is given below.

What is "urgently needed care"? (This is different from a medical emergency)

"Urgently needed care" is **when you need medical attention right away for an unforeseen illness or injury,** and it is not reasonable given the situation for you to get medical care from your PCP or other plan providers. In these cases, your health is *not* in serious danger. As we explain below, how you get "urgently needed care" depends on whether you need it when you are in the plan's Service Area, or outside the plan's Service Area. Section 2 tells about the plan's Service Area.

What is the difference between a "medical emergency" and "urgently needed care"?

The main difference between an urgent need for care and a medical emergency is in the danger to your health. "Urgently needed care" is when you need medical help immediately, but your health is not in serious danger. A "medical emergency" is when you believe that your health is in serious danger.

Getting urgently needed care when you are in the plan's Service Area

If you have a sudden illness or injury that is not a medical emergency, and you are in the plan's service area, please call the Physician Phone number on your membership card. (TTY/TDD users should call the California Relay Service at **711** or **1-800-735-2929**.) There will always be a physician on call to help you. This physician will call you back and tell you what to do. You can also call Health Net's Decision Power Health Coaches anytime, 24 hours a day, seven days a week. Health Net's Decision Power Health Coaches' phone number is **1-800-893-5597**, (TTY **1-800-276-3821**).

Keep in mind that if you have an urgent need for care while you are in the plan's Service Area, we expect you to get this care from plan providers. In most cases, we will not pay for urgently needed care that you get from a non-plan provider while you are in the plan's Service Area.

How to get urgently needed care

Seniority Plus covers urgently needed care that you get from any provider in the U.S. when you are out of Seniority Plus' service area. (See Section 6 for more information on filling your prescription drugs when you are getting urgently needed care and when you are outside the plans service area.)

Section 4 Benefits Chart – a list of the covered services you get as a Member of Seniority Plus

What are "covered services"?

This section describes the medical benefits and coverage you get as a Member of Seniority Plus. **"Covered services" means the medical care, services, supplies, and equipment that are covered by Seniority Plus.** This section has a Benefits Chart that gives a list of your covered services and tells what you must pay for each covered service. The section that follows (Section 5) tells about **services that are *not* covered** (these are called "exclusions"). Section 5 also tells about **limitations** on certain services.

Please refer to Section 15 for additional information regarding 'Mental Health Care and Chemical Dependency Benefits" and Section 16 for additional information regarding the "Optional Supplemental Benefits." This section also includes a list of exclusion and limitations associated with the "Optional Supplemental Benefits."

There are some conditions that apply in order to get covered services

Some general requirements apply to *all* covered services

The covered services listed in the Benefits Chart in this section are covered only when *all* requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare program.
- The medical care, services, supplies, and equipment that are listed as covered services must be Medically Necessary. Certain preventive care and screening tests are also covered. (See Section 17 for a definition of "Medically Necessary.")
- With few exceptions, covered services must be provided by plan providers, be approved in advance by plan providers, or be authorized by Health Net. The exceptions are care for a medical emergency, urgently needed care outside the service area, and renal (kidney) dialysis you get when you are outside the plan's Service Area.

In addition, some covered services require "prior authorization" in order to be covered

Most of the covered services listed in the Benefits Chart in this section are covered only if your doctor or other plan provider gets "prior authorization" (approval in advance) from your medical group, MHN or Health Net Medical Management as applicable. Covered services that need prior authorization are marked in the Benefits Chart "*Requires prior authorization (approval in advance) to be covered, except in an emergency*".

Benefits chart – your covered services	What you must pay when you get these covered services
Inpatient Services	

Inpatient hospital care

Requires prior authorization (approval in advance) to be covered, except in an emergency.

For more information about hospital care, see Section 7.

You are covered for unlimited days per Benefit period.

Covered services include, but are not limited to, the following:

- Semiprivate room (or a private room if Medically Necessary).
- Meals including special diets.
- Regular nursing services.
- Costs of special care units (such as intensive or coronary care units).
- Drugs and medications.
- Lab tests.
- X-rays and other radiology services.
- Necessary surgical and medical supplies.
- Use of appliances, such as wheelchairs.
- Operating and recovery room costs.
- Physical therapy, occupational therapy, and speech therapy services.
- *Under certain conditions, the following types of transplants are covered:* corneal, kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, intestinal/multivisceral. See Section 7 for more information about transplants.
- Blood - including storage and administration Coverage begins with the first pint of blood that you need. Coverage of storage and administration begins with the first pint of blood that you need.
- Physician Services.

You pay:

- $200 copayment each day from Days 1 through 5 per Benefit period, for Inpatient Hospital services.
- $0 copayment each day from Days 6 and beyond per Benefit period, for Inpatient Hospital services.

A Benefit period begins the day you are admitted to a hospital or skilled nursing facility. The Benefit period ends when you have not received hospital and/or skilled nursing care for 60 consecutive days. If you go into the hospital after one Benefit period has ended, a new Benefit period begins. You must pay the inpatient hospital copayment for each Benefit period. There is no limit to the number of Benefit periods you can have.

If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a plan hospital.

Benefits chart – your covered services	What you must pay when you get these covered services
Inpatient mental health care *Requires prior authorization (approval in advance) to be covered, except in an emergency.* Includes mental health care services that require a hospital stay. There is a 190-day lifetime limit in a psychiatric hospital. *The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.* See Section 15, Mental Health Care and Chemical Dependency Benefits, for more information about these benefits.	You pay: - $900 per admission.

Benefits chart – your covered services	What you must pay when you get these covered services
Skilled nursing facility care *Requires prior authorization (approval in advance) to be covered, except in an emergency.* For more information about skilled nursing facility care, see Section 7. You are covered for 100 days each Benefit period. No prior hospital stay is required. Covered services include, but are not limited to, the following: • Semiprivate room (or a private room if Medically Necessary). • Meals, including special diets. • Regular nursing services. • Physical therapy, occupational therapy, and speech therapy. • Drugs (this includes substances that are naturally present in the body, such as blood clotting factors). • Blood - including storage and administration. Coverage begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies. • Laboratory tests. • X-rays and other radiology services. • Use of appliances such as wheelchairs. • Physician services.	Each Benefit period, you pay: - $0 each day for days 1 through 20 for a stay at a Skilled Nursing Facility - $75 each day for days 21 through 100 for a stay at a Skilled Nursing Facility A Benefit period begins the day you are admitted to a hospital or skilled nursing facility. The Benefit period ends when you have not received hospital and/or skilled nursing care for 60 consecutive days. If you go into the skilled nursing facility after one Benefit period has ended, a new Benefit period begins. You must pay the applicable SNF copayment for each Benefit period. There is no limit to the number of Benefit periods you can have.

Benefits chart – your covered services	What you must pay when you get these covered services
Inpatient services (when the hospital or SNF days are not or are no longer covered) For more information, see Section 7. • Physician services. • Tests (like X-ray or lab tests). • X-ray, radium, and isotope therapy including technician materials and services. • Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations. • Prosthetic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices. • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition. • Physical therapy, speech therapy, and occupational therapy.	There is no copayment for the Medicare-covered services listed.
Home health care *Requires prior authorization (approval in advance) to be covered, except in an emergency.* For more information about home health care, see Section 7. Home Health Agency Care: • Part-time or intermittent skilled nursing and home health aid services. • Physical therapy, occupational therapy, and speech therapy. • Medical social services. • Medical equipment and supplies.	There is no copayment for Medicare-covered home health visits.

Benefits chart – your covered services	What you must pay when you get these covered services
Hospice care	
For more information about hospice services, see Section 7.	When you enroll in a Medicare-certified Hospice, your hospice services are paid by Medicare (see Section 7 for more information about hospice services).
• Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Medicare.	
• Home care.	
• Hospice consultation services (one time only) for a terminally ill individual who has not elected the hospice benefit.	$25 copayment for the "one time only" Hospice consultation.
Outpatient Services	
Physician services, including doctor office visits	
• Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center.	You pay $15 for each primary care doctor office visit for Medicare-covered services.
The following require prior authorization (approval in advance) to be covered, except in an emergency:	
• Consultation, diagnosis, and treatment by a specialist.	You pay $25 for each specialist visit for Medicare-covered services.
• Second opinion by another plan provider prior to surgery.	
• Outpatient hospital services.	
• Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor).	

Benefits chart – your covered services	What you must pay when you get these covered services
Chiropractic services *Requires prior authorization (approval in advance) to be covered, except in an emergency. Medicare-covered chiropractic services require prior authorization based on medical necessity and must conform to the PCP's treatment plan.* • Manual manipulation of the spine to correct subluxation.	You pay $10 for each Medicare-covered visit for the manual manipulation of the spine to correct subluxation.
Podiatry services *Requires prior authorization (approval in advance) to be covered, except in an emergency.* • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs. • Routine foot care (non Medicare-covered).	You pay $25 for each Medicare-covered visit (Medically Necessary foot care). You pay $25 for each routine (non Medicare-covered) visit. Care is limited to one visit per calendar month. Additional visits or referrals must be arranged and approved by your PCP.

Benefits chart – your covered services	What you must pay when you get these covered services
Outpatient mental health care (including Partial Hospitalization Services) *Requires prior authorization (approval in advance) to be covered, except in an emergency.* See Section 15, "Mental Health Care and Chemical Dependency Benefits", for more information about these benefits. Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other mental health care professional as allowed under applicable state laws. "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	For Medicare-covered Mental Health services, you pay $25 for each individual or group therapy visit. For partial hospitalization, you pay $0.
Outpatient substance abuse services *Requires prior authorization (approval in advance) to be covered, except in an emergency.* See Section 15, "Mental Health Care and Chemical Dependency Benefits", for more information about these benefits.	For Medicare-covered services, you pay $25 for each individual or group visit.
Outpatient surgery *Requires prior authorization (approval in advance) to be covered, except in an emergency.*	You pay $200 for each Medicare-covered visit to an ambulatory surgical center or an outpatient hospital facility.

Benefits chart – your covered services	What you must pay when you get these covered services
Ambulance services *Non-emergency ambulance transportation requires prior authorization (approval in advance) to be covered.*	
Includes ambulance services to an institution (like a hospital or SNF), from an institution to another institution, from an institution to your home, and services dispatched through **911**, where other means of transportation could endanger your health. Generally, the ambulance benefit is a transportation benefit, and without a transport, there is no payable service.	You pay $125 for Medicare-covered ambulance services (One copayment per day when there is more than one trip in a single day).
Emergency Care For more information, see Section 3.	
• Coverage in the United States* * United States means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.	**Coverage in the United States*** You pay $50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital. If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a plan hospital.
• Worldwide Coverage	**Worldwide Coverage Outside the United States*** There is a combined annual limit of $50,000 for Emergency Services and Urgently Needed Services outside of the United States. There is no copayment or deductible for worldwide Emergency Care services outside the United States.

Benefits chart – your covered services	What you must pay when you get these covered services
Urgently needed care For more information, see Section 3. • Coverage in the United States* * United States means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. • Worldwide Coverage	**Coverage in the United States*** You pay $25 for each Medicare-covered urgently needed care visit. You do not pay this amount if you are immediately admitted to the hospital. **Worldwide Coverage Outside the United States*** There is a combined annual limit of $50,000 for Emergency Services and Urgently Needed Services outside the United States. There is no copayment or deductible for worldwide urgently needed care services outside the United States.
Outpatient rehabilitation services (physical therapy, occupational therapy, cardiac rehabilitation, and speech and language therapy) *Requires prior authorization (approval in advance) to be covered, except in an emergency* Cardiac rehabilitation therapy covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery, and/or have stable angina pectoris.	There is no copayment for Medicare-covered outpatient rehabilitation services.
Durable Medical Equipment and related supplies *Requires prior authorization (approval in advance) to be covered, except in an emergency.* – such as wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. (See definition of "Durable Medical Equipment" in Section 17)	You pay 20% coinsurance based on the Medicare Allowable Cost (MAC).

Benefits chart – your covered services	What you must pay when you get these covered services
Prosthetic devices and related supplies – (other than dental) which replace a body part or function. These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" below for more detail. *Requires prior authorization (approval in advance) to be covered, except in an emergency.*	You pay 20% coinsurance based on the Medicare Allowable Cost (MAC).
Diabetes self-monitoring, training and supplies – for all people who have diabetes (insulin and non-insulin users). *Requires prior authorization (approval in advance) to be covered, except in an emergency.*	
• Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors.	There is no copayment for Medicare-covered diabetes self-monitoring, training and supplies.
• One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts.	There is a 20% coinsurance for therapeutic shoes based on the Medicare Allowable Cost (MAC).
Self-management training is covered under certain conditions. *For persons at risk of diabetes:* Fasting plasma glucose tests. Please call the Member Services Department at the phone number in Section 1 for more information on how often we will cover these tests.	

Benefits chart – your covered services	What you must pay when you get these covered services
Medical nutrition therapy – for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor. *Requires prior authorization (approval in advance) to be covered, except in an emergency.*	There is no copayment for Medicare-covered Medical Nutrition Therapy visit.
Outpatient diagnostic tests and therapeutic services and supplies *Requires prior authorization (approval in advance) to be covered, except in an emergency.*	
• X-rays.	There is no copayment for Medicare-covered X-ray services.
• Radiation therapy. • Complex diagnostic radiology (PET Scan, CT Scan, MRI) • Surgical supplies, such as dressings. • Supplies, such as splints and casts.	Your copayment is based on the Medicare Allowable Cost (MAC) for each Medicare-covered outpatient radiation therapy, complex diagnostic radiology service or medical supply. If the MAC of the Medicare-covered item is between: - $0 and $999, you pay $0 - $1000 and up, you pay $275
• Laboratory tests.	There is no copayment for Medicare covered laboratory services.
• Blood - Coverage begins with the first pint of blood that you need. Coverage of storage and administration begins with the first pint of blood that you need.	There is no copayment for blood and Medicare-covered blood services.

Benefits chart – your covered services	What you must pay when you get these covered services
Preventive Care and Screening Tests	
Bone mass measurements *Requires prior authorization (approval in advance) to be covered, except in an emergency.* *For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if Medically Necessary*: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no copayment for each Medicare-covered Bone Mass Measurement.
Colorectal screening *Requires prior authorization (approval in advance) to be covered, except in an emergency.* *For people 50 and older, the following are covered:* • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. • Fecal occult blood test, every 12 months. *For people at high risk of colorectal cancer, the following are covered:* • Screening colonoscopy (or screening barium enema as an alternative) every 24 months. *For people not at high risk of colorectal cancer, the following is covered:* • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy.	There is no copayment for Medicare-covered Colorectal Screening Exams. Outpatient surgery copayments may apply for colonoscopies preformed in an outpatient hospital facility or ambulatory surgical center. Office visit copayment may apply for services received in the physician's office.

Benefits chart – your covered services	What you must pay when you get these covered services
Immunizations *Generally requires prior authorization (approval in advance) to be covered, except in an emergency.*	
• Pneumonia vaccine (as explained in Section 2, you can get this service on your own, without a referral from your PCP as long as you get the service from a plan provider.)	There is no copayment for the Pneumonia vaccine.
• Flu shots, once a year in the fall or winter. As explained in Section 2, you can get this service on your own, without a referral from your PCP (as long as you get the service from a plan provider.)	There is no copayment for the Flu vaccine.
• *If you are at high or intermediate risk of getting Hepatitis B*: Hepatitis B vaccine.	There is no copayment for the Hepatitis B vaccine.
• Other vaccines if you are at risk.	There is no copayment for other vaccines for those at risk (e.g., anti-rabies vaccine for those possibly exposed to rabies).
Mammography screening (As explained in Section 2, you can get this service on your own, without a referral from your PCP as long as you get it from a plan provider):	
• One baseline exam between the ages of 35 and 39. • One screening every 12 months for women age 40 and older.	There is no copayment for Medicare-covered Mammogram Screenings.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Pap smears, pelvic exams, and clinical breast exam (As explained in Section 2, you can get these routine women's health services on your own, without a referral from your PCP as long as you get the services from a plan provider): • For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months. • If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months.	There is no copayment for Medicare-covered Pap Tests and Pelvic Exams.
Prostate cancer screening exams *Requires prior authorization (approval in advance) to be covered, except in an emergency.* *For men over age 50, the following are covered once every 12 months:* • Digital rectal exam. • Prostate Specific Antigen (PSA) test.	There is no copayment for Medicare-covered Prostate Cancer Screening exams.
Cardiovascular disease testing Blood tests for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). Please call the Member Services Department at the phone number in Section 1 for more information on how often we will cover these tests.	There is no copayment for Medicare-covered cardiovascular screening blood tests.

Benefits chart – your covered services	What you must pay when you get these covered services
Physical exams	
Requires prior authorization (approval in advance) to be covered, except in an emergency.	
• Welcome to Medicare physical exam.	You pay $15 for each Medicare-covered exam.
• Routine annual physical exam.	You pay $15 for each routine physical exam (limited to one exam each year).
Other Services	
Renal Dialysis (Kidney)	
Requires prior authorization (approval in advance) to be covered, except in an emergency.	
• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the Service Area, as explained in Sections 2 and 3). • Inpatient dialysis treatments (if you are admitted to a hospital for special care). • Self-dialysis training (includes training for you and for the person helping you with your home dialysis treatments).	You pay a $25 copayment for Medicare-covered Renal Dialysis (Kidney) services.
• Home dialysis equipment and supplies. Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies when needed, and check your dialysis equipment and water supply).	There is no copayment for Medicare-covered home dialysis services.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Prescription Drugs	
Your provider must get prior authorization from Health Net Seniority Plus for certain prescription drugs. Contact plan for details. That are covered under Original Medicare (these Part B drugs are covered for everyone with Medicare) *Part B Drugs* "Drugs" includes substances that are naturally present in the body, such as blood clotting factors. • Drugs that usually are not self-administered by the patient and are injected while receiving physician services. • Drugs you take using Durable Medical Equipment (such as nebulizers) that was authorized by your Medical Group or Health Net as applicable. • Clotting factors you give yourself by injection if you have hemophilia. • Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare. • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug. • Antigens. • Certain oral anti-cancer drugs and anti-nausea drugs. • Certain drugs for home dialysis, including heparin, the antidote for heparin when Medically Necessary, topical anesthetics, Erythropoietin (Epogen®) or Epoetin Alfa, and Darboetin Alfa (Aranesp®). • Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your home.	You pay 20% coinsurance based on the lesser of Health Net's contracted rate or the Medicare-allowable cost for Medicare-covered Part B Drugs. The minimum coinsurance for Medicare-covered Part B Drugs is $10.

Benefits chart – your covered services	What you must pay when you get these covered services
Prescription Drugs (continued) Prescription drugs (Part D drugs) that are covered if you are enrolled in Seniority Plus because you have enrolled for Medicare Prescription Drug coverage. Section 6 explains about the prescription drug benefit, including rules you must follow to have prescriptions covered. Section 6 also tells about drugs that are not covered by this benefit. This plan uses a formulary. A formulary is a list of all the drugs that we cover. For more information regarding formularies, see Section 6. Generally, you must fill your Part D drugs at a Network -- retail or mail order -- pharmacy, except as noted in Section 6. See Section 17 for a definition of Network Pharmacy and Out-of-Network Pharmacy.	**One-month (30-day) supply of Part D drugs purchased at local pharmacies:** - $5 Copayment – preferred generic - $29 Copayment – preferred brand - $58 Copayment – non-preferred generic or brand - 33% co-insurance - injectable - 33% Co-insurance – specialty drugs **Two-month (60-day) supply of Part D drugs purchased at local pharmacies:** - $10 Copayment – preferred generic - $58 Copayment – preferred brand - $116 Copayment – non-preferred generic or brand - 33% co-insurance - injectable - 33% Co-insurance – specialty drugs **Three-month (90-day) supply of Part D drugs purchased at local pharmacies:** - $15 Copayment – preferred generic - $87 Copayment – preferred brand - $174 Copayment – non-preferred generic or brand - 33% Co-insurance - injectable - 33% Co-insurance – specialty drugs **Two-month (60-day) supply of Part D drugs purchased via mail order:** - $10 Copayment – preferred generic - $58 Copayment – preferred brand - $116 Copayment – non-preferred generic or brand - 33% Co-insurance - injectable - 33% Co-insurance – specialty drugs

Benefits chart – your covered services	What you must pay when you get these covered services
Prescription Drugs (continued)	**Three-month (90-day) supply of Part D drugs purchased via mail order:** - $10 Copayment – preferred generic - $58 Copayment – preferred brand - $145 Copayment – non-preferred generic or brand - 33% Co-insurance - injectable - 33% Co-insurance – specialty drugs After the total yearly drug costs (paid by both you and your plan) reach $2,250, you pay 100% of your prescription drug costs up until your yearly out-of-pocket drug costs reach $3,850. After your yearly out-of-pocket drug costs reach $3,850, you pay the greater of: - $2.15 for generic (including brand drugs treated as generic) and - $5.35 for all other drugs, or - 5% coinsurance. Certain prescription drugs will have maximum quantity limits, generic substitutions, or may require prior authorization. Contact plan for details.
Additional Benefits	
Dental services Services by a dentist are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor.	There is no copayment for Medicare-covered dental services.

Benefits chart – your covered services	What you must pay when you get these covered services
Hearing services	
Requires prior authorization (approval in advance) to be covered, except in an emergency.	
• Diagnostic hearing exams.	You pay 100% for hearing aids. You pay $25 for each Medicare-covered hearing exam (diagnostic hearing exams).
• Routine hearing exams.	You pay $25 for each routine hearing test up to 1 test every year.
Vision care	
Requires prior authorization (approval in advance) to be covered, except in an emergency.	
• Outpatient physician services for eye care. • *For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year*	You pay $25 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye).
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. *Prior Authorization is not required for Medicare-covered eyewear.*	There is no copayment for Medicare-covered eyewear (one pair of eyeglasses or contact lenses after each cataract surgery).
• Routine (non-Medicare covered) vision exams	You pay $25 for each Routine eye exam, limited to 1 exam every year.
Health and wellness education programs	
	There is no copayment for the following: - Written health education materials, including newsletter - Nutritional Training - Smoking Cessation - Decision Power

Extra benefits you can buy (these are called "optional supplemental benefits")

Seniority Plus offers some extra benefits that are not covered by Original Medicare and not included in your benefits package as a Plan Member. These extra benefits are called "**Optional Supplemental Benefits.**" If you want these Optional Supplemental Benefits, you must sign up for them and you may have to pay an additional premium for them.

Optional Supplemental Benefit Packages **Premium, Monthly Plan Premium and Other Important Information**	
****Package – 1****	You pay $15 each month in addition to the monthly plan premium of $100 and the Medicare Part B premium, for these optional benefits: - Chiropractic Services - Acupuncture - Health and Fitness Services - Dental Services - Vision Services
Chiropractic Services *(no initial authorization or referral for first time visits; authorization required for subsequent visits and treatments)*	You pay $10 for each routine visit up to 30 visits every year (combined with Acupuncture). Please refer to Section 16, "Optional Supplemental Benefits" for further information regarding chiropractic services. Medicare-covered chiropractic services, manual manipulation of the spine to correct subluxation, are covered under the medical benefit. Please see "Chiropractic Services" under "Outpatient Services" earlier in this section.
Acupuncture *(no initial authorization or referral for first time visits; authorization required for subsequent visits and treatments)*	You pay $10 for each routine visit up to 30 visits every year (combined with Chiropractic Services).

	Please refer to Section 16, "Optional Supplemental Benefits" for further information regarding acupuncture services.
Health and Fitness – Silver&Fit™ *This program is designed specifically for Medicare beneficiaries that incorporates exercise and health education to help you become physically fit.*	There is no copayment for health club and fitness benefits. Please refer to Section 16, "Optional Supplemental Benefits" for further information regarding health and fitness benefits.
Dental Services – (DHMO)	You pay: - $0 to $15 for each oral exam - $0 to $40 for each cleaning up to 1 visit every 6 months - $0 for each fluoride treatment - $0 for dental x-rays Additional dental benefits are available. Please refer to Section 16, "Optional Supplemental Benefits" for further information regarding dental services.
Vision Services	There is no copayment for the following items: - Glasses, limited to 1 pair of glasses every two years* - Contacts, limited to 1 pair of contacts every two years* - Lenses, limited to 1 pair of lenses every two years* - Frames, limited to 1 frames every two years* You are covered up to $100 for eye wear every 2 years.* *multi-year benefits may not be available in subsequent years. The maximum benefit for medically

	necessary contact lenses is $250 during a 24-month period.* There is a $100 frame allowance; you pay 80% of the remaining balance. There is a $100 contact lens allowance; you pay 85% of the remaining balance. *multi-year benefits may not be available in subsequent years. For further information on your Optional Supplemental Vision Services (including the Eyewear Schedule, limits and exclusions), please refer Section 16, "Optional Supplemental Benefits"
****Package – 2****	You pay $18 each month in addition to the monthly plan premium of $100 and the Medicare Part B premium, for these optional benefits: - Chiropractic Services - Acupuncture - Health and Fitness Services - Dental Services - Vision Services
Chiropractic Services *(no initial authorization or referral for first time visits; authorization required for subsequent visits and treatments)*	You pay $10 for each routine visit up to 30 visits every year (combined with Acupuncture). Please refer to Section 16, "Optional Supplemental Benefits" for further information regarding chiropractic services. Medicare-covered chiropractic services, manual manipulation of the spine to correct subluxation, are covered under the medical benefit. Please see "Chiropractic Services" under "Outpatient Services" earlier in this section.

Acupuncture *(no initial authorization or referral for first time visits; authorization required for subsequent visits and treatments)*	You pay $10 for each routine visit up to 30 visits every year (combined with Chiropractic Services). Please refer to Section 16, "Optional Supplemental Benefits" for further information regarding acupuncture services.
Health and Fitness – Silver&Fit™ *This program is designed specifically for Medicare beneficiaries that incorporates exercise and health education to help you become physically fit.*	There is no copayment for health club and fitness benefits. Please refer to Section 16, "Optional Supplemental Benefits" for further information regarding health and fitness benefits.
Dental Services – (DPPO) You can see any licensed dentist to receive covered preventative dental services. However, your cost shares are higher when you receive covered services from non-plan providers than from plan providers. Dental services are offered through Health Net Dental network providers. Health Net Dental providers are listed in your Directory of PPO Dental Providers. Routine preventive (non-Medicare covered) dental services include: • 1 oral exam per 12 months, once every 12 months • 1 cleanings per 12 months, once every 12 months • Bitewing x-rays once every 12 months • Panoramic x-rays once every 36 months (multi-year benefits may not be available in subsequent years).	In Network -You pay a one time annual deductible of $35. You pay $0 copayment for in network services. Out-of-Network- You pay a $35 annual deductible plus 20% of the cost (Health Net Dental pays 80% of the usual and customary rate (UCR) after you pay the $35 deductible). You will be responsible for the difference between UCR and the billed charges. For plan and non-plan providers there is a combined annual maximum benefit for routine preventive dental services of $500. Please refer to Section 16, "Optional Supplemental Benefits" for further information regarding dental services.

Vision Services	There is no copayment for the following items: - Glasses, limited to 1 pair of glasses every two years* - Contacts, limited to 1 pair of contacts every two years* - Lenses, limited to 1 pair of lenses every two years* - Frames, limited to 1 frames every two years* You are covered up to $100 for eye wear every 2 years.* The maximum benefit for medically necessary contact lenses is $250 during a 24-month period.* There is a $100 frame allowance; you pay 80% of the remaining balance. There is a $100 contact lens allowance; you pay 85% of the remaining balance. * multi-year benefits may not be available in subsequent years. For further information on your Optional Supplemental Vision Services (including the Eyewear Schedule, limits and exclusions), please refer Section 16, "Optional Supplemental Benefits"

Members may disenroll from these Optional Supplemental Benefits at anytime and revert back to the basic Seniority Plus plan. You may disenroll from the Optional Supplemental Benefits by sending a letter to Health Net Seniority Plus requesting to be disenrolled. It is important that you state your request is for Disenrollment from the Optional Supplemental Benefits only and the letter must be signed. We will then send you a letter that tells you when your Optional Supplemental Benefits will end. This is your Optional Supplemental Benefits **Disenrollment date.** In most cases, your Disenrollment date will be the first day of the month after the month we receive your request to discontinue these benefits.

For example, if we receive your request to discontinue these benefits during the month of February, your Disenrollment date will be March 1. There is an exception: **One exception occurs in November—if we receive your requests between November 15 and November 30, you will be allowed to choose either December 1 or January 1 as your effective date of Disenrollment. If you do not choose an effective date, your Disenrollment will be effective on December 1**. Remember, while you are waiting for your discontinuation of your Optional Supplemental Benefits, they are still available to you as a Member of Seniority Plus and are available up until the Disenrollment effective date.

Members who disenroll may not re-enroll until the next election period. The available election periods for the Optional Supplemental Benefits are from November 15, 2006 through December 31, 2006 for a January 1, 2007 effective date, the first 30 days in January for a February 1, 2007 effective date, or from May 15, 2007 through June 30, 2007 for a July 1, 2007 effective date.

Members who fail to pay the monthly premium for the Optional Supplemental Benefits will lose the benefits but will remain enrolled in the basic Seniority Plus plan. The Optional Supplemental Benefits included in this section are subject to the same appeals process as any other benefits. See Sections 10 and 11 for information about making complaints. For a detailed explanation of these benefits, including limitations and restrictions, please see Section 16, "Optional Supplemental Benefits", for more information.

What if you have problems getting services you believe are covered for you?

If you have any concerns or problems getting the services that you believe are covered as a member, we want to help. Please call us at Member Services at the telephone number in Section 1. You have the right to make a complaint if you have problems related to getting services or payment for services that you believe are covered as a member. See Section 10 for information about making a complaint.

Can your benefits change during the year?

Generally your benefits will not change during the year. The Medicare program does not allow us to *decrease* your benefits during the calendar year. We are allowed to decrease your benefits only on January 1, at the beginning of the next calendar year. The Medicare program must approve any *decreases* we make in your benefits. We will tell you in advance (in October

2007) if there are going to be any increases or decreases in your benefits for the next calendar year that begins on January 1, 2008.

At any time during the year, the Medicare program can change its national coverage. Since we cover what Original Medicare covers, we would have to make any change that the Medicare program makes. These changes could be to increase or decrease your benefits, depending on what change the Medicare program makes. In some cases, if your benefits increase, Original Medicare will pay for the benefit for the rest of the calendar year. In those cases, you will have to pay Original Medicare out-of-pocket amounts for those services. We will let you know in advance if you will have to pay Original Medicare out-of-pocket amounts for an increased benefit.

Can the prescription drugs that we cover change during the year?

The Medicare program allows us to make changes in our prescription drug formulary list at any time during the calendar year. As we explain in Section 6, the formulary is a list of drugs. A change in our drug formulary list could affect which drugs are covered for you or how much you have to pay when you fill a covered prescription. Note that the formulary list applies only to the covered services listed in the Benefits Chart under the heading that says, "Seniority Plus Prescription Drug Benefit (outpatient prescription drugs)."

Section 5 Medical care and services that are NOT covered or limited (list of exclusions and limitations)

Introduction

The purpose of this section is to tell you about medical care and services that are not covered ("excluded") or are limited by Seniority Plus. The list below tells about these exclusions and limitations. The list describes services that are not covered under *any* conditions, and some services that are covered only under specific conditions. (The Benefits Chart in Section 4 also explains about some restrictions or limitations that apply to certain services).

If you get services that are not covered, you must pay for them yourself

We will not pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will Original Medicare, unless they are found upon appeal to be services that we should have paid or covered (appeals are discussed in Sections 10 and 11).

What services are not covered, or are limited by Seniority Plus?

In addition to any exclusions or limitations described in the Benefits Chart in Section 4, or anywhere else in this booklet, **the following items and services are not covered except as indicated by** Seniority Plus:

1. Services that are not covered under Original Medicare, *unless* such services are specifically listed as covered in Section 4.
2. Services that you get from non-plan providers, *except* for care for a medical emergency and urgently needed care, renal (kidney) dialysis services that you get when you are temporarily outside the plan's Service Area, and care from non-plan providers that is arranged or approved by a plan provider. See other parts of this booklet (especially Sections 2 and 3) for information about using plan providers and the exceptions that apply.
3. Services that you get without a referral from your PCP, when a referral from your PCP is required for getting that service.
4. Services that you get without prior authorization, when prior authorization is required for getting that service. (Section 4 gives a definition of prior authorization and tells which services require prior authorization.)
5. Services that are not reasonable and necessary unless according to the standards of original Medicare unless these services are otherwise listed by Seniority Plus as a covered service. As noted in Section 4, we provide all covered services according to Medicare guidelines.
6. Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency. (See Section 3 for more

information about getting care for a medical emergency).

7. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or unless for certain services covered under an approved clinical trial. Experimental procedures and items are those items and procedures determined by Health Net and Original Medicare to not be generally accepted by the medical community. See Section 7 for information about participation in clinical trials while you are a Member of Seniority Plus.

8. Surgical treatment of morbid obesity *unless* Medically Necessary and covered under Original Medicare.

9. Private room in a hospital, *unless* Medically Necessary.

10. Private duty nurses.

11. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.

12. Nursing care on a full-time basis in your home.

13. Custodial care is not covered by Seniority Plus *unless* it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. "Custodial care" includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.

14. Homemaker services.

15. Charges imposed by immediate relatives or members of your household.

16. Meals delivered to your home.

17. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance unless medically necessary.

18. Cosmetic surgery or procedures, *unless* it is needed because of accidental injury or to improve the function of a malformed part of the body. Breast surgery is covered for all stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast.

19. Routine dental care (such as cleanings, fillings, or dentures) or other Non-routine dental services. Certain dental services that you get when you are in the hospital will be covered. However, routine dental care is available under the Optional Supplemental Benefits. See the end of Section 4 for a discussion about how you can buy Optional Supplemental Benefits.

20. Chiropractic care is generally not covered under the plan, (with the exception of manual manipulation of the spine, as outlined in Section 4) and is limited according to Medicare